STRATEGIC PLAN
FY 2010 - FY 2014

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Mississippi Division of Medicaid

5-Year Strategic Plan
FY 2010 – 2014

Mission

To ensure access to health services for the Medicaid eligible population in the most cost efficient and comprehensive manner possible and to continually pursue strategies for optimizing the accessibility and quality of health care.

Overview

The Division of Medicaid seeks to provide high quality, cost-effective health-care services to all qualified beneficiaries. The Division of Medicaid continues to develop innovative and cost-efficient programs to allow for the provision of maximum health benefits to qualified eligibles. The Division of Medicaid will seek to greatly improve the status of healthcare across the state and create a platform to cease reacting to illness and empower beneficiaries to be proactive and focus on prevention, wellness; and avoidance of chronic disease.

The Division of Medicaid has established goals and strategies to position Medicaid as a leading provider of health-care services as follows:

- Improve the effectiveness and efficiency of the delivery of medical services.
- Maximize revenue by containing costs, eliminating duplication, and using all sources of funds.
- Attract and maintain a strong network of service providers by continuously evaluating and implementing programs that strengthen the reimbursement process.
- Continue to enhance and introduce up-to-date management information and communication systems/equipment.
- Provide continuous improvement/utilization review by evaluating service outcomes, program costs, and provider participation to maximize and effectively manage resources.

Our success in meeting these goals will be measured by our performance in the following categories:

- Beneficiary, provider, and employee satisfaction determined via survey.
- Methodologies developed to evaluate service delivery and outcomes.
- Standards implemented to ensure uniformity and cost-effective service.
- Program oversight and monitoring to identify and eliminate fraud, waste, and abuse.
- Monitoring staff performance, competence, training, and retention.

The Division of Medicaid is committed to developing a healthcare partnership with policy makers, beneficiaries, providers, and stakeholders from the community to provide maximum healthcare benefits to qualified individuals through innovative and cost effective programs.

Performance Effectiveness Objectives

The Division of Medicaid proposes to complete the following objectives:

I. Administer a cost-effective, efficient, and responsive Medicaid program

a. Utilize care management and care coordination programs and processes to promote beneficiary self-care and wellness, prevention of disease complications, and cost-effective service delivery.
b. Develop initiatives for enhanced cost effectiveness of Medicaid service delivery based on data and evidence-based guidelines for health care, including networking with other State Medicaid programs to share new initiatives along with shortfalls and successes experienced.
c. Promote and enhance the beneficiary's knowledge base of the Medicaid program and services offered through a structured and organized outreach and education platform.
d. Maintain, recruit, and attract qualified, trained, and competent work force dedicated to life-long learning.

II. Sustain and maximize available funds

a. Ensure only qualified individuals are enrolled in the Medicaid and CHIP programs by continuing the current practice of in-person interviews, requiring appropriate verifications and maintaining supervisory reviews of all eligibility decisions.
b. Continuously analyze revenue sources to assure maximum revenue collection through new grant opportunities, assessments, proper disproportionate share collections, upper payment limits, waiver and demonstration programs, third party sources, etc.
c. Increase available alternatives to nursing home care by aggressively pursuing increased funding for the Home and Community Based Services Waiver programs.
d. Maintain and enhance the agency's online financial reporting system to increase interagency coordination of day-to-day financial decisions and effectively manage long term budgeting processes.
e. Continuously analyze agency administrative expenses to ensure appropriate use of state and federal funds.
f. Integrate new technologies with fraud detection and case tracking systems to improve the effectiveness and efficiency of fraud and abuse investigations.
g. Monitor the performance of contractors to ensure the contractors provide quality services in accordance with contractual requirements and that funds expended are accurate and correct.

III. Ensure accuracy and correctness of payments

a. Develop a comprehensive provider billing manual that defines the reimbursement methodologies by program, provider type, and/or service.
b. Monitor claims processing for all categories of service to ensure accurate payments and identify and correct errors.
c. Update the claims processing system regularly to ensure compliance with Health Insurance Portability and Accountability Act (HIPAA) regulations.
d. Evaluate the impact of the reimbursement methodologies on provider participation.
e. Develop incentive programs for all provider types to increase and maintain provider participation and evaluate performance of quality services rendered to the beneficiaries.

IV. Enhance automation and computer systems

a. Improve the quality of healthcare provided to Medicaid beneficiaries by participating in health information exchanges, providing e-prescribing capabilities and implementing a secure electronic health record that will provide historical medical and prescription information.
b. Improve agency level efficiency by expanding the implementation of imaging technology.
c. Provide statewide and local network systems support for the efficient use of the Medicaid's network and Interfacing Agencies.
d. Implement a fully web based process for the Medicaid's long term care eligibility pre-admission screening.
e. Promote increased utilization of the web portal as a tool for beneficiaries and providers.

Significant External Factors Which May Affect Performance

The Division of Medicaid is committed to maximizing and effectively managing resources by working with key policy makers, providers, beneficiaries, collaborative partners, and employees to contain costs. It is anticipated that the following external factors may affect our ability to reach our stated goals and objectives.

- Federal/State legislation which limits coverage groups or benefits.
- Reduction in federal funding.
- Lack of Support from the provider community.
- Inability to recruit and retain qualified professionals such as nurses, accountants, and pharmacists.
- Advances in medical technology that place demands on policy and systems development, as well as increased reimbursement.
- Expectations by providers and beneficiaries for the Medicaid program to mirror service changes in the private sector and Medicare programs.
- Limited financial resources for needed technological improvements.
- Problems resulting from retirement of key employees.

Internal Management System

The Division of Medicaid has developed an organizational infrastructure which includes communications, innovation, planning, budgeting, on-going development, and enhancing the agency's research and data collection to provide sound information for decision making and ensuring quality of care to the people we serve. The Division of Medicaid continues to recruit, develop, cross train, and retain a knowledgeable and well-trained workforce to provide analysis and plan activities and functions. Efforts are made to ensure maximal compliance with mandated and optional program guidelines, as well as continually seek efficiencies in our internal operations. The Division of Medicaid is committed to evaluating staff annually to ensure that we are meeting their individual, professional, and employment development, as well as agency-wide goals and objectives.